Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NUEVA VIDA BEHAVORIAL HEALTH ASSOCIATES
5555 FREDERICKSBURG RD, STE 102
SAN ANTONIO, TX 78229

Respondent Name
TRAVELERS PROPERTY CASUALTY CO

Carrier's Austin Representative Box
Box Number 05

MFDR Tracking Number
M4-12-3065-01

MFDR Date Received
JUNE 6, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The dates of service being denied for payment are 2/5/10, 5/12/10, 5/21/10, 5/18/10, 6/14/10, 7/20/10, 7/28/10, 8/11/10, 7/22/10, and 9/8/10. This date of service was performed and denied however a CCH was performed and ruled in favor of the patient and Travelers was ordered to pay."

Amount in Dispute: $1,368.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier contends the Provider is not entitled to additional reimbursement. The Carrier, therefore, respectfully requests the Division determine no additional reimbursement is due for this service."

Response Submitted by: Travelers, 1501 S. Mopac Expressway, Ste A-320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 5, 2010 to September 8, 2010	90801, 90806, 99361, 90885	$1,368.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 14, 2010
   - W12-Extent of injury. Not finally adjudicated.

   Explanation of benefits dated July 16, 2010

- W9-Description not available

Explanation of benefits dated August 12, 2010
- W12-Extent of injury. Not finally adjudicated.

Explanation of benefits dated August 16, 2010
- W12- Extent of injury. Not finally adjudicated.

Explanation of benefits dated September 7, 2010
- W12- Extent of injury. Not finally adjudicated.

Explanation of benefits dated September 10, 2010
- W12- Extent of injury. Not finally adjudicated.

Explanation of benefits dated October 8, 2010
- W1-Workers Compensation State F/S adj. Payment denied based on Medicare payment policy.

Explanation of benefits dated October 15, 2010
- W12- Extent of injury. Not finally adjudicated.

Explanation of benefits dated October 22, 2010
- W12- Extent of injury. Not finally adjudicated.

Explanation of benefits dated November 9, 2010
- W4-No additional reimbursement allowed after review of appeal/reconsideration. Issue

Explanation of benefits dated December 16, 2010
- W4-No additional reimbursement allowed after review of appeal/reconsideration.

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1)(B)(i) states, " A request may be filed later than one year after the date(s) of service if: "a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability." A Contested Case Hearing (CCH) decision was issued on March 2, 2012. The requestor did not submit documentation to support their date of receipt of the CCH decision. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on June 6, 2012, which is 96 days after the decision was issued. The Division concludes that the requestor has failed to provide sufficient documentation to support that this dispute was timely filed with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/03/2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.